

(4) The total cost of purchasing such coverage, including administrative expenditures, the costs of paying all cost sharing charges in excess of the amounts imposed by the agency under subpart A of part 447, and the costs of providing benefits as required by (a)(2) of this section, must be comparable to the cost of providing direct coverage under the State plan.

(b) A State may not require an individual to receive benefits through premium assistance under this section, and a State must inform an individual that it is the individual's choice to receive either direct coverage under the Medicaid State plan or coverage through premium assistance for an individual health plan. A State must require that an individual who elects premium assistance obtain through the insurance coverage all benefits for which the insurer is responsible and must provide the individual with information on how to access any additional benefits and cost sharing assistance not provided by the insurer.

[78 FR 42303, July 15, 2013]

Subpart L—Options for Coverage of Special Groups under Presumptive Eligibility

SOURCE: 66 FR 2667, Jan. 11, 2001, unless otherwise noted.

§ 435.1100 Basis for presumptive eligibility.

This subpart implements sections 1920, 1920A, 1920B, 1920C, and 1902(a)(47)(B) of the Act.

[81 FR 86460, Nov. 30, 2016]

§ 435.1101 Definitions related to presumptive eligibility.

For the purposes of this subpart, the following definitions apply:

Application means, consistent with the definition at § 435.4, the single streamlined application adopted by the agency under § 435.907(a); and

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

(1) In the case of a child on whose behalf a Medicaid application has been

filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or eligibility of a child for child health assistance under the State Children's Health Insurance Program;

(6) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(7) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(8) Is a State or Tribal child support enforcement agency;

(9) Is an organization that—

(i) Provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

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(ii) Is a State or Tribal office or entity involved in enrollment in the program under title XIX, Part A of title IV, or title XXI; or

(iii) Determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*);

(10) Is a health facility operated by the Indian Health Service, a Tribe or Tribal organization under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 *et seq.*), or an Urban Indian Organization under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 *et seq.*).

(11) Any other entity the State so deems, as approved by the Secretary.

Services means all services covered under the plan including EPSDT (see part 440 of this chapter).

[66 FR 2667, Jan. 11, 2001, as amended at 66 FR 33822, June 25, 2001; 81 FR 86460, Nov. 30, 2016]

§ 435.1102 Children covered under presumptive eligibility.

(a) The agency may elect to provide Medicaid services for children under age 19 or a younger age specified by the State during a presumptive eligibility period following a determination by a qualified entity, on the basis of preliminary information, that the individual has gross income (or, at state option, a reasonable estimate of household income, as defined in § 435.603 of this part, determined using simplified methods prescribed by the agency) at or below the income standard established by the State for the age of the child under § 435.118(c) or under § 435.229 if applicable and higher.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must—

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities—

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a regular Medicaid application form;

(iii) Within five working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that—

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application.

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency; and

(vi) Do not delegate the authority to determine presumptive eligibility to another entity.

(3) Establish oversight mechanisms to ensure that presumptive eligibility determinations are being made consistent with the statute and regulations.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

(d) The agency—

(1) May require, for purposes of making a presumptive eligibility determination under this section, that the

individual has attested to being, or another person who attests to having reasonable knowledge of the individual's status has attested to the individual being, a—

(i) Citizen or national of the United States or in satisfactory immigration status; or

(ii) Resident of the State; and

(2) May not—

(i) Impose other conditions for presumptive eligibility not specified in this section; or

(ii) Require verification of the conditions for presumptive eligibility.

(e) Notice and fair hearing regulations in subpart E of part 431 of this chapter do not apply to determinations of presumptive eligibility under this section.

[43 FR 45204, Sept. 29, 1978, as amended at 77 FR 17212, Mar. 23, 2012; 78 FR 42304, July 15, 2013]

§ 435.1103 Presumptive eligibility for other individuals.

(a) The terms of §§ 435.1101 and 435.1102 apply to pregnant women such that the agency may provide Medicaid to pregnant women during a presumptive eligibility period following a determination by a qualified entity that the pregnant woman has income at or below the income standard established by the State under § 435.116(c), except that coverage of services provided to such women is limited to ambulatory prenatal care and the number of presumptive eligibility periods that may be authorized for pregnant women is one per pregnancy.

(b) If the agency provides Medicaid during a presumptive eligibility period to children under § 435.1102 or to pregnant women under paragraph (a) of this section, the agency may also apply the terms of §§ 435.1101 and 435.1102 to the individuals described in one or more of the following sections of this part, based on the income standard established by the state for such individuals and providing the benefits covered under that section: §§ 435.110 (parents and caretaker relatives), 435.119 (individuals aged 19 or older and under age 65), 435.150 (former foster care children), and 435.218 (individuals under age 65 with income above 133 percent FPL).

(c)(1) The terms of §§ 435.1101 and 435.1102 apply to individuals who may be eligible under § 435.213 of this part (relating to individuals with breast or cervical cancer) or § 435.214 of this part (relating to eligibility for limited family planning benefits) such that the agency may provide Medicaid during a presumptive eligibility period following a determination by a qualified entity described in paragraph (c)(2) of this section that—

(i) The individual meets the eligibility requirements of § 435.213; or

(ii) The individual meets the eligibility requirements of § 435.214, except that coverage provided during a presumptive eligibility period to such individuals is limited to the services described in § 435.214(d).

(2) Qualified entities described in this paragraph include qualified entities which participate as providers under the State plan and which the agency determines are capable of making presumptive eligibility determinations.

[78 FR 42304, July 15, 2013]

§ 435.1110 Presumptive eligibility determined by hospitals.

(a) *Basic rule.* The agency must provide Medicaid during a presumptive eligibility period to individuals who are determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible subject to the same requirements as apply to the State options under §§ 435.1102 and 435.1103, but regardless of whether the agency provides Medicaid during a presumptive eligibility period under such sections.

(b) *Qualified hospitals.* A qualified hospital is a hospital that—

(1) Participates as a provider under the State plan or a demonstration under section 1115 of the Act, notifies the agency of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures;

(2) At State option, assists individuals in completing and submitting the full application and understanding any documentation requirements; and

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(3) Has not been disqualified by the agency in accordance with paragraph (d) of this section.

(c) *State options for bases of presumptive eligibility.* The agency may—

(1) Limit the determinations of presumptive eligibility which hospitals may elect to make under this section to determinations based on income for all of the populations described in §§ 435.1102 and 435.1103; or

(2) Permit hospitals to elect to make presumptive eligibility determinations on additional bases approved under the State plan or an 1115 demonstration.

(d) *Disqualification of hospitals.* (1) The agency may establish standards for qualified hospitals related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who:

(i) Submit a regular application, as described in § 435.907, before the end of the presumptive eligibility period; or

(ii) Are determined eligible for Medicaid by the agency based on such application.

(2) The agency must take action, including, but not limited to, disqualification of a hospital as a qualified hospital under this section, if the agency determines that the hospital is not—

(i) Making, or is not capable of making, presumptive eligibility determinations in accordance with applicable state policies and procedures; or

(ii) Meeting the standard or standards established by the agency under paragraph (d)(1) of this section.

(3) The agency may disqualify a hospital as a qualified hospital under this paragraph only after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.

[78 FR 42304, July 15, 2013]

Subpart M—Coordination of Eligibility and Enrollment Between Medicaid, CHIP, Exchanges and Other Insurance Affordability Programs

SOURCE: 77 FR 17212, Mar. 23, 2012, unless otherwise noted.

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§ 435.1200 Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs.

(a) *Statutory basis, purpose, and definitions.*

(1) *Statutory basis and purpose.* This section implements section 1943(b)(3) of the Act as added by section 2201 of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs.

(2) *Definitions.* (i) *Combined eligibility notice* has the meaning as provided in § 435.4.

(ii) *Coordinated content* has the meaning as provided in § 435.4.

(iii) *Joint fair hearing request* has the meaning provided in § 431.201 of this chapter.

(b) *General requirements and definitions.* The State Medicaid agency must—

(1) Fulfill the responsibilities set forth in paragraphs (d) through (h) of this section and, if applicable, paragraph (c) of this section.

(2) Certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility.

(3) Enter into and, upon request, provide to the Secretary one or more agreements with the Exchange, Exchange appeals entity and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to—

(i) Minimize burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for enrollment in a QHP or for one or more insurance affordability program;

(ii) Ensure compliance with paragraphs (d) through (h) of this section and, if applicable, paragraph (c) of this section;

(iii) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under § 435.912, based on the date the application is submitted to any insurance affordability program;